REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

NAVRONGO HEALTH RESEARCH CENTRE

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GIVE US THIS DAY OUR DAY SCHOOL

The Navrongo Initiative

In the Kassena Nankana District of the Upper East Region of Ghana, health for all has become a reality. Community Health Nurses (CHN) have been retrained, equipped, and deployed to live in villages to provide door-to-door and compound-specific health care services to the rural poor. The questions raised in Cairo at the 1994 ICPD have been answered comprehensively in sixteen communities where community members have constructed "Level A" clinics known as Community Health Compounds (CHC). These clinics, and a doorstep service delivery system that accompanies their construction improves access to quality and efficient health care. A system of community mobilization has been developed to augment the community health programme with durbars, outreach to chiefs, mobilization of male and female social networks, and information directed to the needs of men. Taken together, the CHFP represents a model for community health care that can be replicated in districts throughout Ghana.

The need for a model CHO training component of the CHPS Initiative. In 1999, the national effort to scale up the Navrongo CHFP was instituted in a policy statement calling for a coordinated programme of translating static services into community-based health and family planning care based on the Navrongo model. To facilitate the process of operational change, a highly decentralized approach was instituted in which district teams would visit Navrongo for a training programme. Training would emphasize the process of pilot trial in other localities, and adaptation of the Navrongo system to local realities and needs. Priority in this programme was placed on starting work in 10 "lead districts" where unusual commitment to the initiative was manifest.

District teams have been trained in Navrongo in a counterpart model. In this approach, the District Health Management Team (DHMT), a sub-district supervisor, and one or two CHO are trained to start Navrongo-like operations in one or more sub-districts. When experience with this programme showed that CHO needed applied community-based training in community liaison, community-based service delivery, and special care to broaden their technical skills, a component of the Navrongo training programme was added to accommodate trainees from the four existing nurse training centres. However, since the training capacity of these centres is limited, any add-on module to their programme is, by definition, inadequate. There is a clear need to demonstrate a CHO training capability that includes the existing classroom curriculum and adds the Navrongo CHFP community counterpart orientation component.

The CHFP nurse staffing requirements. At various stages of the programme, the CHFP has seen an exodus of nurses for further training that continually threatens to destabilize the integrity of the research programme. At present, only 14 of the 16 study villages have resident CHO owing to regional staff shortages. The problem of CHO shortages will expand in 2003 when the CHFP plans to extend operations into communities that do not at present have resident nurses. The full complement of CHO required for the district by 2003 will be 33 nurses plus the 16 required for existing CHC. By addressing this shortage, Navrongo can lead the way in demonstrating a model for low-cost, sustainable, and replicable means of supplying communities with CHO. Existing abandoned structures will be used in a cost-effective development of a training centre for the Upper East Region.

Even under the CHFP nurses for compound-specific health service are in short supply

Our Day School

The Kassena Nankana District is suitable for setting up a training school for the following reasons:

1. An ideal field site exists where theory is linked to practice. There are 16 retrained CHN who live in communities and offer doorstep services and compound-specific health education thus fulfilling the objective of training CHN.
2. The availability of human resources at the NHRC as well as the University for Development Studies for training.
3. The presence of modern facilities such as a computer centre, a reasonably equipped library, a video laboratory, and dissemination centre that can be used by students.
4. There are projects running at the Centre in which students can participate.

It is envisaged that the day school will eliminate the burden of hostel facilities, dining halls, and other structures that characterize all boarding schools. Students will commute every day from their homes to attend lectures. Field experiences will take place in health institutions including CHC.

Former MCH building ready to receive the first 50 students of the model Day CHO training school

While we will rely on the Human Resource Directorate to provide core staff, we will also draw on the NHRC and the region's abundant human resources for teaching purposes. Several individuals have completed graduate and diploma health programmes and are working in the District and region. The University for Development Studies has a campus in the District, which will also be a resource for the school.

The regional and District health, traditional, and political authorities are united behind the Day School initiative and are determined to see it succeed. The building formerly occupied by the MCH that has been earmarked to host the school and staff has already been relocated to the War Memorial Hospital in Navrongo. The structure is undergoing renovation to bring it to the required standard for use as both classroom and offices. A nine-member committee has been formed and charged with preliminary implementation work and is presently working in earnest towards the successful realization of the project.

Nature of training

Semester programmes will be run with emphasis on practical attachment to counterpart CHO. Host CHO will act as supervisors and consultants to trainee nurses in the communities so that student nurses are exposed to practical daily encounters and "learn by doing". CHO have been trained to treat minor ailments, give compound-specific talks, provide reproductive health services including emergency deliveries, EPI, referral, and mobilize communities for health action. Sub-district staff as well as DHMT and NHRC staff will also supervise students.

A portion of semester breaks will be spent both in the student's home region for further practical experience in maternity, MCH, FP services, and a portion with District CHO. In addition to core instructors and facilitators, tutors from existing schools in the region will be utilized for teaching various courses. Field experience will be conducted in all six districts at Health Centres to be identified by the DHMT. The regional hospital as well as the five District Hospitals will be used as field sites. Periodic exchange visits will be paid to the Tamale Nurses Training School.

The teaching methods will combine lectures, roleplay, demonstrations, discussions, case studies, and audiovisual aids such as documentaries. Teachers will be invited from other Community Health Nurses Training (CHNT) schools to offer assistance. Interim assessment will be done periodically and teachers from the traditional CHNT schools will moderate semester exam questions.

If the Navrongo Day Community Health Nurses Training School makes it, and progress and enthusiasm so far suggest that it will, districts across the country will be drawing another lesson from the ongoing Navrongo CHFP whose seeds are already sprouting countrywide.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant from the Vanderbilt Family to the Population Council.